



MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: TEXOMA MEDICAL CENTER 3255 W PIONEER PKWY ARLINGTON TX 76013	MFDR Tracking #: M4-10-3709-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: NEW HAMPSHIRE INSURANCE CO Box #: 19	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by TEXOMA MEDICAL CENTER to audit their Workers Compensation claims. We have found in this audit they have not paid what we determine is the correct allowable per the Medicare fee schedule..."

Amount in Dispute: \$270.38

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: A response to the Request for Medical Fee Dispute Resolution was not submitted.

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
06/14/2009	99283-25	\$135.19 x 200% = \$270.38	\$270.38	\$270.38
			Total Due:	\$270.38

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, effective for medical services provided in an outpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for hospital outpatient services.

This request for medical fee dispute resolution was received by the Division on April 21, 2010.

- For the services involved in this dispute, the respondent did not review this CPT code on the first submission of the bill or the request for reconsideration.
- Division rule at 28 TAC §134.403(e) states, in pertinent part, that "Regardless of billed amount, reimbursement shall be:
(1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or
(2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;"
- Pursuant to Division rule at 28 TAC §134.403(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors

as published annually in the *Federal Register*. The following minimal modifications shall be applied.

- (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
 - (A) 200 percent; unless
 - (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.”
4. Under the Medicare Outpatient Prospective Payment System (OPPS), all services are classified into groups called Ambulatory Payment Classifications (APCs). Services in each APC are clinically similar and require similar resources. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Within each APC, payment for ancillary and supportive items and services is packaged into payment for the primary independent service. Packaged services are considered integral to the primary paid service and are not separately reimbursed. An OPPS payment status indicator is assigned to each HCPCS code. The status indicator for each HCPCS code is shown in OPPS Addendum B, and a full list of status indicators and their definitions is published in Addendum D1 of the OPPS proposed and final rules each year, both of which are publicly available from the Centers for Medicare and Medicaid services.
5. According to the table of disputed services CPT Code 99283-25 is the only service in dispute. Review of the UB-04 shows that this code was billed; however, in reviewing the initial and reconsideration explanation of benefits it was not audited by the respondent. This particular code is a Status V code. A Status V code is defined as a clinic or emergency department visit. This visit may include an ER physician or personal physicians and is payable under the Medicare OPPS. Therefore, reimbursement is recommended.
6. Upon review of the documentation submitted by the Requestor and Respondent, the Division finds that:
 - (1) No documentation was found to support a contractual agreement between the parties to this dispute;
 - (2) MAR can be established for these services; and
 - (3) Separate reimbursement for implantables was NOT requested by the requestor.

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code §413.031(c), the Division concludes that the requestor is due payment. As a result, the amount ordered is \$270.38.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.305, §133.307, §134.403
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is / is not entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$270.38 plus accrued interest per Division rule at 28 TAC §134.130 and §413.019 (if applicable), due within 30 days of receipt of this order.

DECISION/ORDER:

Authorized Signature

Medical Fee Dispute Resolution Officer

March 14, 2011

Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.